MEMORANDUM

DATE: October 31, 2007

TO: Mr. Harris Taylor
Director of Program Accountability
Division of Substance Abuse and Mental Health

FROM: Daniese McMullin-Powell, Chairperson
State Council for Persons with Disabilities

RE: 11 DE Reg. 448 [Substance Abuse Facility Licensing Regulations]

The State Council for Persons with Disabilities (SCPD) has reviewed the Department of Health and Social Services/Division of Substance Abuse and Mental Health's (DSAMH) proposal to replace its licensing regulations applicable to substance abuse facilities. The regulations were published as 11 DE Reg. 448 in the October 1, 2007 issue of the Register of Regulations. SCPD has the following observations.

First, it is unclear whether the regulations apply to children's facilities. The licensing statutes [Title 16 Del.C. §§2206(1), 2207, and 2208] authorize DHSS to adopt standards, in consultation with the DSCY&F, for adult and children's facilities. DHSS is also authorized to delegate to the DSCY&F the authority to issue regulations for children's facilities. There is no recital in the regulations that DSCY&F has been consulted. Moreover, all the references in the lengthy regulation are to DSAMH to the exclusion of DSCY&F. SCPD identified only three references [§5.1.4.4.1.14; §5.1.7.1.1.2; §7.1.2.1.7] which suggest coverage of children's facilities since they require reporting of child abuse or neglect. DSAMH should clarify whether the standards apply to both adult and child facilities. If the standards do apply to children's facilities, DSAMH should consider revisions to address children. For example, residential facilities and some day programs should ensure that minors receive schooling. Cf. Title 16 Del.C. §5161(a)(12)[residential mental health facilities must ensure education of minors].

Second, the definition of "counseling" in §3.0 only permits "face-to-face interaction" between counselor and clients, family members, and significant others. The regulations include some minimum amounts of such "counseling". See, e.g., §§10.1.8, 11.1, and 12.1. Literally, the regulation may

categorically preclude use of videoconferencing, teleconferencing and other communication technologies. Such modalities may be necessary to promote participation by family members and significant others. The Division should consider authorization of such modalities at least under some circumstances (e.g. family is distant or lacks transportation). Moreover, the Division may wish to clarify whether videoconferencing amounts to "face-to-face interaction".

Third, SCPD was pleased to note that the definition of "medical history" in §3.0 affirmatively references "head injuries". Given the "underidentification" of TBI, SCPD endorses this provision.

Fourth, §4.5.2.1 requires compliance with the ADA in license applications. Likewise, §7.1.1.3 requires compliance with ADA standards. SCPD endorses these provisions.

Fifth, in §4.13.4 there are some extraneous brackets "[]".

Sixth, §4.15.4 invariably requires any waiver granted by the Division to extend for the full term of the existing license, i.e., up to 2 years. This unnecessarily limits the Division's discretion. For example, there may be circumstances under which a short-term waiver would be more appropriate. DSAMH should consider adopting the approach reflected in DLTCRP regulations covering DDDS neighborhood homes, 16 DE Admin Code 3310, §17.4. Section 17.4 provides as follows: "A waiver may be granted for a period up to the term of the license."

Seventh, at least in the context of residential facilities, it is preferable to require that notice of the waiver request be shared with residents to permit input from persons who may be most affected . Compare 16 DE Admin Code 3310, §17.1.4. No harm is done by promoting the opportunity for consumer input into waiver requests.

Eighth, §5.1.1.4 requires the facility's Governing Body to meet only once annually. If DSAMH wishes to promote an active, knowledgeable board, this standard may fall short of achieving that objective.

Ninth, facilities are required to make mandated reports of child abuse [§§5.1.4.4.1.16; 5.1.7.1.1.2; and 7.1.2.1.7]. There is no comparable provision requiring reporting of abuse, mistreatment, neglect, or financial exploitation as required by Title 16 Del.C. §2224. This oversight should be corrected.

Tenth, there is an anomaly in §6.1. Section 6.1.2.1.1 requires the Clinical Director to have a "master's degree in counseling or a related discipline." Section 6.1.3.1.1. requires a Clinical Supervisor to have a bachelor's degree with "a major in chemical dependency, psychology, social work, counseling, or nursing." The "related discipline" standard applicable to the Clinical Director is ostensibly narrower than the educational background standards for the Clinical Supervisor (degree in chemical dependency, psychology, social work, counseling, or nursing). For example, could a Clinical Director qualify with a master's degree in nursing? DSAMH may wish to clarify "related discipline" by at least providing some specific examples of acceptable contexts of degrees.

Eleventh, §7.1.1.1 is problematic. It recites as follows:

> No program shall deny any person equal access to its facilities or services on the basis of race, color, religion, ancestry, sexual orientation, gender expression, national origin, or disability, unless such disability makes treatment offered by the program non-beneficial or hazardous.

[emphasis supplied] The underlined exclusion is an inane standard which is not consistent with the ADA, §504, or the Equal Accommodations statute (Title 6 Del.C. Ch. 45). It is also inconsistent with §7.1.3.1. For example, it would authorize a program to deny services to a Deaf applicant since the Deaf applicant could not benefit from the existing program. Legally, the program must provide accommodations to ensure that its program is beneficial to the applicant with disabilities. In this example, the program should not be barring the Deaf client from admission. It should be providing a sign-language interpreter. Similarly, there is no "hazardous" exception in the ADA [28 C.F.R. §§35.149-35.150 (public entities); 28 C.F.R. §36.302(private entities)]. For example, it may be "hazardous" for a person with ambulatory limitations to climb a stairway to an upper floor location. However, rather than denying that person services, the provider should be providing accommodations (e.g. moving counseling session to ground floor). If a specialty program does not offer the type of treatment that a person with a disability seeks, the program is expected to make a referral to another program. See 28 C.F.R. §36.302(b). If an applicant poses a "direct threat" or "safety" risk to a private provider, that assessment must be made in the context of accommodations. [28 C.F.R. §§36.208 and 36.301].

Twelfth, §7.1.2.1.9 should be expanded to include a reference to advocates and advocacy agencies. See Title 16 Del.C. 2220(17).

Thirteenth, §7.1 would benefit from addition of a "catch-all" provision requiring compliance with Title 16 Del.C. §2220. This would be consistent with §8.1.2.1.2.11.1, which requires programs to provide notice of such rights to clients.

Fourteenth, §§8.1.2 and 8.1.3 could be strengthened in the context of discharge planning. Compare, in the mental health context, §5161(b)(4), which contemplates that the discharge plan be developed in consultation with anticipated post-discharge providers. See also DLTCRP mental health group home regulations, 16 DE Admin Code 3305, §6.8.

Fifteenth, requiring facilities to only maintain records for 12 months [§8.1.4] is too short. Contrast the DLTCRP mental health group home regulations [16 DE Admin Code 3305, §8.1] which require that records be maintained for 7 years!

Sixteenth, there is an extraneous reference to §8.1.2.2 in the margin next to §10.1.6.

Seventeenth, §12.4.2.2.1 authorizes restrictions on phone use. Such restrictions may be precluded by Title 16 Del.C. §2220(11).

Eighteenth, §14.1.1.1.6 categorically precludes admission to opioid treatment services unless the

applicant has been addicted at least 1 year. This categorical exclusion may unnecessarily limit provider clinical judgment and discretion. This provision should be deleted from the regulations.

Nineteenth, the rationale for precluding admission to opioid treatment services by someone released from a penal institution within 6 months [§14.2.1] may also unduly restrict provider discretion. For example, the applicant could have been in a penal institution (e.g. pre-trial pending release on bail) for only a few days.

Twentieth, in §14.7, it would be preferable to include a provision requiring that the applicant be provided with the specific reasons for denial of admission. Indeed, public entities would be required to provide such information as a matter of due process.

Twenty-first, §14.18.3 categorically bars admission of a client for more than 2 detoxification treatment episodes in 1 year. It is unclear why such a restriction would be included in a licensing standard. If an applicant wishes to "private pay" for detoxification, or an insurer will cover such costs, why should the State categorically preclude access to detoxification? If DSAMH wishes to impose such a standard for detoxification paid for by the State, it could do so by contract. Otherwise, providers should be allowed to exercise professional discretion.

Twenty-second, the regulations to do not appear to include a standard in the context of criminal background checks. The regulations would benefit from such a reference.

Thank you for your consideration and please contact SCPD if you have any questions or comments regarding our observations or recommendations on the proposed regulations.

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DelARF
Governor's Advisory Council to DSAMH
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